STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155365	A. BUILDING 01 B. WING	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASH SKILLED CARE CENTER	710 N EAST ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/09/12 and a Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/06/12 Facility Number: 000256 Provider Number: 155365 AIM Number: N/A Surveyor: Amy Kelley, Life Safety Code Specialist At this PSR survey, Wabash Skilled Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000	Wabash Skilled Care CenterID NO. 155365Visit Completion Date: 7/6/2012ISDH Plan of CorrectionJuly 26, 2012Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 5, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	This facility located on the third floor of a four story building with a basement was determined to be of Type I (443) construction was fully sprinklered. This survey includes the entire third floor due to the lack of two hour separation between the Skilled Care Center and the remaining third floor occupancy. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The resident room do not have smoke detection at this time. The facility has a capacity of 25 and had a census of 17 at the time of this survey. The facility was found not in compliance with state law in regard to smoke detector coverage and sprinkler coverage. Only one area where residents have customary access was not sprinklered, the bottom of the west stairwell exit was not sprinklered. All areas providing facility services were sprinklered Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/12/12.			

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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 3 stairwells in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-13.3.2 states in noncombustible stair shafts with noncombustible stairs, sprinklers shall be installed at the top of the shaft and under the first landing above the bottom of the shaft. Exception: Sprinklers shall be installed beneath landings or stairways where the area beneath is used for storage. This deficient practice could affect any resident	K0056	Wabash Skilled Care CenterID NO. 155365Visit Completion Date: 7/6/2012ISDH Plan of CorrectionJuly 26, 2012Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 5, 2012.K056 It is the intent of this facility to ensure that a sprinkler system is provided in the stairwell in accordance with NFPA 13. What corrective actions will be accomplished for those	08/05/2012

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	evacuated through west stairwell. Findings include: Based on an observation with Maintenance Technician # 8 on 07/06/12 at 2:25 p.m., the west stairwell lacked sprinkler coverage at the bottom of the stairwell. This was acknowledged by Maintenance Technician # 8 at the time of observation. 3.1-19(b) 3.1-19(ff)		residents found to have been affected by the deficient practice? The west stairwell, lowest level, will be sprinkled. A proposal for the work has been received and approved. Staff in Wabash Skilled Care Center have been notified of the course of action in the event of a fire. How will the facility identify other residents having the potiential to be affected by the same deficeient practice and what corrective action will be taken?All residents have the potential to be affected by the alleged deficiency. The west stairwell, lowest level, will be sprinkled. A proposal for the work has been received and approved. Staff in Wabash Skilled Care Center have been notified of the course of action in the event of a fire. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?The automatic sprinkler system will be tested in accordance with NFPA 25.How will the corrective action be monitored to ensure the deficient practice does not recur?The automatic sprinkler system will be tested in accordance with NFPA 25.Quality Assurance follow-up:The Facility Services Leader will report test findings to the Quality Assurance Committee quarterly.Date of Compliance: 8/5/2012	

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K9999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012. This State Rule has not been met as evidenced by: Based on Record review and interview, the facility failed to install smoke detectors in each resident's room before July 1, 2012. This deficient practice	K9999	K9999 It is the iuntent of this facility to ensure that a smoke detector will be located within each resident room.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?Each resident room will be equipped with a smoke detector.How will the facility identify other residents having the potiential to be affected by the same deficeient practice and what corrective action will be taken?All residents have the potential to be affected by the alleged deficient practice. As of 7/9/2012 all resident rooms have been equipped with a smoke detector.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?All smoke detectors will be tested per manufacturer recommendations.How will the corrective action be monitored to ensure the deficient practice does not recur?All smoke detectors will be tested per manufacturer recommendations.Quality Assurance follow-up:The Facility Services Leader will report test findings to the Quality Assurance Committee quarterly.Date of Compliance: 7/9/2012	07/09/2012

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	could affect at least 17 residents in the facility. Findings include: Based on observations with Maintenance Technician # 8 on 07/06/12 from 2:12 p.m. to 2:17 p.m., the resident rooms were not provided with smoke detectors. Based on interview during the time of observations, Maintenance Technician # 8 acknowledged all the resident rooms were not provided with smoke detectors. 3.1-19(ff)			